72 West Jimmie Leeds Road, Suite 1100
Galloway, New Jersey 08205
Phone: 855-677-9729
Fax: 855-677-9783

ONCOLOGY AUTHORIZATION REQUEST FORM

1 PATIENT INFORMATION (PLEASE INCLUDE PATIENT DEMO SHEET, IF AVAILABLE)

Patient Name: ______________________ DOB: _____ /_____ /_____ Gender (Circle): M F

Address: ______________________

City: ______________ State: ________ Zip Code: ____________ Phone: ______-______-______

Insurance Company Name: ______________________ Policy ID #: ______________

2 PROVIDER INFORMATION

ATTENDING PHYSICIAN

Name: ______________________

Fax #: ______________________

INS Provider / Tax ID#: ______________________

Reason for Exam: ______________________

Diagnosis, Staging, Re-staging, Suspected Recurrence, Surveillance

Diagnosis 1: ______________________ ICD10 Code 1: ______________

Diagnosis 2: ______________________ ICD10 Code 2: ______________

For new cancer diagnosis, please include type of cancer and date of diagnosis: ______________________

____

Clinical History (Please include lab results, radiology results, prior treatment, symptoms, including duration): (MANDATORY)

____

____

Findings from prior radiology exams: ______________________

Tissue diagnosis: ❑ Yes ❑ No

Rising Tumor Markers: ❑ Yes ❑ No If yes, please indicate which one(s) and value(s) ______________

Chemotherapy (Start Date): ______ / ______ / ______ Chemotherapy (End Date): ______ / ______ / ______

Radiation (Start Date): ______ / ______ / ______ Radiation (End Date): ______ / ______ / ______

3 AUTHORIZATION REQUEST FOR RADIOLOGY (MANDATORY)

❑ PET/CT

❑ Brain
❑ Cardiac
❑ Oncology (Skull - Mid Thigh)
Type of Cancer ______________
❑ Melanoma (whole body)
❑ Other ______________

CPT Code: ______________

Isotope agent:
❑ FDG ❑ NaF

❑ CT

❑ With & Without Contrast
❑ Without Contrast ❑ With Contrast

❑ Abdomen
❑ Chest, Thorax
❑ Head
❑ Neck
❑ Pelvis
❑ Other ______________

CPT Code: ______________

❑ MRI

❑ With & Without Contrast
❑ Without Contrast ❑ With Contrast

❑ Abdomen ❑ Neck
❑ Brain ❑ Pelvis
❑ Breast, Bilateral
❑ Chest, Thorax
❑ Head
❑ Other ______________

CPT Code: ______________

❑ Please notify me __________ days before authorization expiration.

Submitted by: ______________________ Phone #: ______________ Date: ______ / ______ / ______

4 **Fax completed forms to: 855-677-9783**